COSMOS
Navigate the Compliance Universe

Compliance Today - February 2022
Revisions to Medicare's split/shared visit rule

By Daniel F. Shay, Esq.

Daniel F. Shay (dshay@gosfield.com) is an Attorney at Alice G. Gosfield & Associates PC in Philadelphia.


Daniel F. Shay

For decades, Medicare has adhered to a dizzying array of Byzantine billing rules, among them the "incident-to" rule[1] and the "split/shared visit" rule. The latter of these two, however, underwent significant changes during the latter part of 2021, and will face additional changes during 2022 and 2023. This article explores these changes, giving a brief overview of the previous version of the rule, the intermediate changes that occurred, and an explanation of where things stand currently.

Historical overview

Prior to 2021, the split/shared visit rule was meant to provide an option for physicians and certain nonphysician practitioners (NPPs) to work collaboratively in an institutional setting and bill for patient visits at the higher physician rate. Similar to the incident-to rule, the split/shared visit rule allowed a physician to see a patient in a hospital inpatient, outpatient, or emergency department setting for an evaluation and management (E/M) visit and share that visit with an NPP, while being paid at 100% of the Medicare Physician Fee Schedule (MPFS) rate under the physician's name, provided the physician had a face-to-face encounter with the patient. However, this rule applied only in the hospital inpatient, outpatient, and emergency department settings, where the incident-to rules did not apply.

The Centers for Medicare & Medicaid Services (CMS) had established this rule in the past, simply by promulgating manual language (originally in the *Medicare Carriers Manual*, and later in the *Medicare Claims Processing Manual*). The manual language, however, was withdrawn on May 9, 2021, in response to a petition under the Department of Health & Human Services' good guidance regulations, following an administrative challenge to the rule.[2] The crux of the challenge was that, contrary to the requirements of the *Allina* case,[3] the rule had not gone through the necessary notice and comment period. Accordingly, CMS withdrew the rule, only to publish a revised version in the 2022 MPFS Final Rule.[4] From that time until January 1, 2022, physicians were only able to bill for split/shared visits on the basis of their own time spent with the patient, with the NPP having to submit a separate claim under the NPP's name for the NPP's time.

The new landscape

The 2022 MPFS final rule reinstated many aspects of the previous split/shared visits rule, but with several modifications. While many of these modifications represent expansions in how and when practitioners may take advantage of the rule, others impose new limitations.

Under the new rule, split/shared visits are E/M visits performed in a facility setting by a physician and an NPP who are in the same group, furnished in accordance with the coverage requirements for E/M services generally if performed by either the physician or NPP. The new rule expands the settings beyond hospitals to include skilled

nursing facilities and nursing facilities. In addition, while the previous rule only permitted split/shared visits for established patients, the new rule is applicable to both established and new patients.

With respect to new restrictions, one of the more significant changes to the rule pertains to the method by which the physician and NPP must determine who is the billing practitioner. Both the old and new rules require that a physician perform a "substantive portion" of the visit to qualify as a split/shared visit. However, the old rule defined substantive portion to mean *any* face-to-face portion of the visit. This meant that a physician could poke their head into a visit to convert it to a split/shared visit billable at the higher physician rate. Under the new rule, the visit must be billed by whichever practitioner performed the "substantive portion,"[5] but this term has been redefined.

As of January 1, 2023, the practitioner who performs more than half of the total time spent with the patient is considered to have performed the substantive portion. This definition will apply throughout 2022 as well, but to ease the transition to a strictly time-based analysis, CMS will also allow an alternative method to determine who performed the substantive portion, specifically where one practitioner performs one of three key components of a visit: a history of present illness (HPI), physical exam (PE), or medical decision-making (MDM). The component itself must be performed in its entirety by the practitioner who bills for it. In other words, if the NPP performs the HPI and PE, and the physician only performs a portion of the MDM, the visit cannot be billed under the physician's number.

One possible area of confusion is how the service should be billed if the physician performs only one of the three key portions (e.g., MDM), and the NPP performs the other two, or performs one and splits the other evenly with the physician (e.g., the NPP performs 100% of the HPI but only 50% of the PE). The preface to the new rule does not address this issue directly but implies that the practitioners may select a single portion to be considered the substantive portion, which would mean that as long as a physician performs 100% of at least one portion, the visit may be billed under the physician's number.

Specifically, the language in the preface states, "the substantive portion will be defined as one of the three key components" but later describes scenarios where a portion "is used as the substantive portion," suggesting that the practitioners may select the portion among the three options.[6] The preface also elaborates on how practitioners should bill when they share time on one of the three key components, indicating that the billing practitioner must select the appropriate level of code based on the level of service the billing practitioner alone has performed.

The regulators also explained how to handle joint time as opposed to "distinct time" with respect to determining the substantive portion. In general, the distinct time of one practitioner may be counted toward determining which performed the substantive portion of the visit. However, when two or more practitioners meet with or discuss the patient, only the time of one individual may be counted. As an example, CMS describes a scenario wherein the NPP spends the first 10 minutes of a visit with the patient and the physician then spends another 15 minutes, in which case the total time would equal 25 minutes, and the physician would bill for the service. However, if the physician and NPP met together for five additional minutes (bringing the total to 30 minutes), the overlapping time could only be counted for purposes of establishing total time, and the physician would be said to have spent 20 minutes with the patient (and therefore, because it represents more than half of the total time, still the substantive portion of the visit). In other words, the five minutes spent by the NPP that overlap with the five minutes the physician spends could not be counted together.

The new rule also includes a list of 12 activities that may be counted for purposes of determining total time, including preparing to see the patient (e.g., reviewing test results); travel time; obtaining and/or reviewing separately obtained history; ordering medications, tests, or procedures; and counseling and educating the

patient, and/or their family, and/or their caregiver.[7] This list will apply only for calculations of total time. For the 2022 calendar year, HPI, PE, or MDM *or* performing more than half the total time may be used as the measures for determining the substantive portion.

A careful examination of the list of activities that may be used to count toward time will note that many do not require actual face-to-face time with the patient. The regulators explicitly acknowledge this change in response to a comment asking whether CMS's intent was to require either of or both practitioners to have face-to-face contact with the patient. In response, CMS explained "the list of qualifying activities for time do not specify whether each activity is face-to-face or not. To our knowledge, CPT has not defined the terms 'face-to-face' and 'non-face-to-face,' but in this context we interpret face-to-face to mean in-person....Our intent was that only one of the practitioners must perform the in-person part of an E/M [evaluation and management] visit when it is split (or shared), although either or both can do so. We acknowledge that Medicare policy on this was not clear in the past....We are finalizing as proposed that *the substantive portion can be comprised of time that is with or without direct patient contact*" (emphasis added).[8] In other words, while the substantive portion requirement has risen beyond merely poking one's head into a visit, the new requirements permit a physician to never meet with the patient face-to-face at all, as long as the physician performs the substantive portion of the visit and the level selected for the visit conforms with the amount of time spent by the physician.

One final aspect of the rule change that warrants scrutiny is the requirement that the physician and NPP be in the same group. First, the regulators make clear that when a physician and NPP are *not* in the same group, their respective services should be billed separately and then only for the services they each perform fully. For services where the physician and NPP each perform a portion of the service, the regulators explain that when they are in different groups, "we would not consider either service to be a billable service."[9] Interestingly, the regulators declined to define "same group" in this rulemaking, although they received several suggestions as to how to define such a term. The suggestions included tying the definition to the Stark definition of a group practice, considering the specialty of the physician and NPP, being employees or independent contractors of the same entity, and having the same taxpayer identification number, among others. Nevertheless, the regulators refused to define the term, stating, "We intend to monitor our claims data, and we thank the commenters for their recommendations and insights into current practice, which we may consider for future rulemaking."[10]

The new rule also imposes new documentation requirements on the practitioners performing the split/shared visit. First, the medical record must identify the two practitioners who perform the visit, and the billing practitioner must sign and date the medical record. In addition, beginning in the 2022 calendar year, split/shared visits must be billed with a specific modifier, although the modifier itself is not specified in the final rule.

Conclusion

Most of the changes to the split/shared rule are meant to help modernize the application of the rule. The change to a strict time-based measure in 2023 (and the 2022 "key component" measure) for determining the substantive portion tracks with changes to Medicare's approach to E/M services, condensing the number of levels of service and altering how those levels are determined. The measures to calculate time likewise permit scenarios in which the physician never actually meets with the patient face-to-face at all. Of course, this will be the first year implementing such rules, and CMS may change its policies moving forward, but for the foreseeable future, the revised split/shared rule should be easier for physicians who work with NPPs in facility settings to use.

Takeaways

- The split/shared billing rule was removed from May 9, 2021, until new regulations took effect on January 1,

2022. Between those dates, no split/shared visits could be billed under either version of the rule.

- The billing practitioner must perform a "substantive portion" of the visit to bill the split/shared visit. When measuring using time, this means more than half of the total time spent with the patient.
- Activities that qualify for the substantive portion may include time not spent face-to-face with the physician, such as travel time, obtaining and/or reviewing a separately obtained history, or counseling the patient and/or their family and/or caregiver.
- For the 2022 calendar year, substantive portion may also include performing a history of present illness, physical exam, or medical decision-making when performed entirely by the billing practitioner.
- Although split/shared visits must be billed by a physician and nonphysician practitioner in the same group, the Centers for Medicare & Medicaid Services has declined to define what constitutes a "group" and rejected using the Stark Law definition of the term.

1 42 C.F.R. § 410.26.
2 Centers for Medicare & Medicaid Services, "CMS Notice Regarding Split (or Shared) Evaluation and Management Visits and Critical Care Services from May 26, 2021 through December 31, 2021," May 26, 2021, https://www.cms.gov/files/document/enf-instruction-split-shared-critical-care-052521-final.pdf (CMS's response to the petition). The original petition itself can be found at the end of CMS's response document.
3 Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).
4 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64,996 (November 19, 2021).
5 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 65,151.
6 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 65,153.
7 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 65,154.
8 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 65,155.
9 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 65,157.
10 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 65,158.